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Tales from a medical apprenticeship: reflections on supporting empathy

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Abstract

This article brings together and uses some tales describing experiences from my medical training to draw out a number of themes that seem relevant to person-centred healthcare in England, UK and indeed, perhaps, elsewhere. The first of these is the suffering and disability which doctors deal with every day in their work. Second, there is the privilege of practice and the risk it brings of practitioners becoming immune, as it were, to suffering. Third, there is the complexity of healthcare and the effect of government efforts to sort out some of these problems and the attempts of managers to implement new policies. The glib adoption of 'in' and 'fashionable' phrases, however, belies an ignorance of the complexity of patients' problems that makes delivering person-centred care so important and sometimes so difficult. Hopefully, these tales show how far things have moved towards developing care that truly centres around the person who is ill. I offer some reflections from a long journey now to argue that the task of new structures should be to *support* staff to do their job better, not to *manage* them into carrying out an entirely different administrative function.

Keywords

Active listening, clinical experience, empathy, managing clinical staff, medical apprenticeship, medical history taking, narrative medicine, patient-centered care, person-centered care, reflective practice, supporting clinical staff

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Introduction

I was first tempted to collect together these tales ten years ago when colleagues seemed to rather like some short pieces about my medical training that I had published in the *British Medical Journal*. Secretly, I realised I had enjoyed writing these more than the research articles I was supposed to be finishing at the time. No need to obsess over method or references, only to try to describe what I had seen, heard and felt. I was coming to the end of a 20-year medical apprenticeship in which I had been lucky enough to take an unusual route around the English National Health Service (NHS). Some experiences, however, remained puzzling and I wanted to put them together to see how they looked. I must beg the reader's indulgence, therefore, for providing a personal and essentially parochial view about hospital care in England, UK.

A long time ago in the 1980s I took a year out from my medical training to study medical sociology. After a seminar on professional socialisation, another student pointed out that I was in an ideal position to study how students became doctors. I did manage to keep a detailed diary for one year, but the aim of medical school is after all

not to fashion a visiting sociologist, but rather a native doctor. Inevitably, my 'field notes' tailed off, although I continued to write notes on events that moved me. Much later, as I began to organise these, I found that other memories came 'bubbling up', as if it was each one for itself. I have grouped some of these and drawn out the three main themes that they seem to convey.

Individual suffering and disability

It is said that every picture tells a story and that each of us has a novel within us. The first task a medical student has to learn during the clinical part of their training is how to see the 'right' story - or to take a history - from the person in front of them. To begin with, clinical students feel anxiety about ever being able to remember and ask about the large number of possible symptoms and how to synthesise them to begin to make a diagnosis. And as well as being able to elicit the right information there is the issue of how they can steer the patient away from their own narrative or 'novel'. So, using one example from my family, the medical history might seek to document the right-sided weakness and a fluent dysphasia developing a

week before in a 92-year old woman with a history of atrial fibrillation. It would not necessarily document her smile at the birth of a late grandchild, record her anxiety during the pregnancy that evoked the premature birth of her own twins many years before, or know the pleasure of the nurses and her family that she survived for five months to hold her grandchild in her 'good' arm.

The strict focus of the medical history, as it was taught to me, is one of the first things, I think, that risks diminishing empathy with the individual suffering and disability that doctors deal with. As a medical student I was struck by patients' stories, but I found that if I put too much narrative (or the 'social') into those I presented, my harder teachers would remonstrate with me for writing what they described as 'English essays'. But, influenced by Oliver Sacks, I have wanted to put the patient back into their history. My first tale, which follows, is from this early period of clinical training as a medical student.

Tale 1: The devil in the test tube [1]

He was thin and weak and his voice almost inaudible, despite the relative quiet of a teaching hospital side room. By the time I joined the firm as a student, he had endured pyrexia of unknown origin for over one month. Allocating him to me, the house officer had explained that his hairy cell leukaemia should be curable, were it not that the source of his fever remained stubbornly elusive. Instead, he lay drained, submitting to repeated blood cultures and increasingly invasive investigations.

After retiring as a schoolmaster, he had trained as a missionary and travelled widely. All manner of latent exotic infections might be coming back to haunt him, but all the test results were negative. Finding a good vein for the blood samples became difficult and I tried optimistically to explain each new investigation. We exhausted this bit of game playing after a while and we moved on to the new direction in his work. Being single and used to teaching boys, he seemed to find the daily attention of a female student novel and I sensed him applying his mind to me, summing up my performance and potential.

Living far from London he had few visitors, which may have been a mixed blessing. He recounted a visit by one of his younger more evangelical colleagues: '*Do you know, he suggested that the Devil may be here - somewhere in my illness.*' With sardonic glee he recalled his retort: '*Well if the Devil is here, he's at the bottom of a test tube now.*'

But it was an effort for him to talk, his voice so low that I could not always catch what he said and sometimes he would collapse back onto the bed, trying to hide his exasperation. Once he did ask, '*Are you sure your hearing is alright?*' '*Oh yes,*' I replied, '*my friends sometimes ask, but my GP says I should pay more attention.*'

The weeks passed and so did Christmas, though no positive results arrived. He was weaker, his pyjamas flapped around him and his watch was broken. On the morning of Christmas Eve he gave me money to buy a replacement. He was so overwhelmed by the structure this brought back to his days, he offered me money as a present. '*No,*' I said, putting him off, '*buy me a book on Theology when you are better.*'

In the New Year I moved to another firm and visited less often. But I learnt from the house officer that someone had reviewed the original bone marrow aspirate and spotted

atypical mycobacteria. I found my patient cheerfully contemplating the diagnostic puzzle. '*Isn't it interesting?*' he mused. '*It was there all the time, we just couldn't see it.*' He started receiving treatment and my visits dropped off. Some six months later, I met him by chance in the outpatients' clinic - stronger, upright and sporting a beard. I was so surprised my words came out unchecked. '*What's happened to you?*' I demanded. '*I've got better,*' he pronounced, lifting his stick and heading off for his appointment. I quite forgot to report that he had prompted me to go back to my general practitioner and ask for some hearing tests. These had revealed a low frequency hearing loss. Weak patients and mumbling consultants are simply outside my range. I never did get the book on Theology but two devils had indeed been found out.

What I hope this tale conveys is that by spending time with people one learns more about them, their disease and, sometimes, about oneself. But I am not going to pretend that this is as easy for a practitioner in a very busy practice as it is for a student. It requires a mastery of both the clinical and the social which one senior clinician remarked comes later in life when you '*become more interested in the people who have diseases rather than the diseases they have*'. Another clinician described the formative experience of seeing how a medical team managed a severe illness in a close family member in a way that ignored or missed crucial elements about those people and their family.

The second tale is a less happy one from my house officer year about how we all have to face our own mortality.

Tale 2: What a rotten job you've got [2]

He was a large man with gynaecomastia and he was covered in bruises. The day before, his general practitioner had sent him up to hospital for a full blood count. The phlebotomist he saw had taken enough blood for a clotting screen and this had revealed disseminated intravascular coagulation. He had been admitted urgently to the ward on which I was house officer. There my efforts to obtain more blood were failing as each vein I tried ballooned and bled into his skin. I sweated, he contained his irritation and finally there were a few more millilitres.

With some relief I stood near the door, talking in general terms about further tests. '*What do you think's the cause of this blood not clotting then?*' he asked. He had been diagnosed 17 years before with prostatic cancer and had taken stilboestrol long term, but I did not know what, if anything, he had been told about the implications of this new development. His directness caught me off guard. '*I don't know. Sometimes it can, be, er, an after effect of the, er, prostate.*' He frowned, looking as if he were trying to make sense of me. I made a polite escape.

The next day I apologised to my consultant for the small blood sample. '*Don't worry,*' she said as we walked to the patient's room, '*his bone marrow is stuffed with malignancy. There's nothing we can do. He could bleed suddenly or last several weeks. I'm going to tell him now.*' She sat down to tell him that he was dying and I busied myself on the ward.

Afterwards, a ward nurse, wincing in the direction of his room, asked me to write up some pain control for him. Hesitating, I went into his room to fetch his drug chart. '*I'll*

not stay if you don't want me to,' I said. 'No stay,' he said gratefully, 'I'd like to talk. I've been waiting 17 years for this and I sort of knew when you said last night. I knew what you wanted to do - to let me down gently - I sort of knew anyway.' He turned away and, looking out of the window, he added, *'God. What a rotten job you've got.'* I stared at him as he looked out into the watery sunlight of that Winter day. I had no idea what I had been trying to do and I wondered at his equanimity. He turned back, *'It's my wife I worry about. I just don't know how she's going to react. She could go to pieces and she's losing her job soon. I feel uneasy about going home too. Of course there are these new places - hospices - that might be a thing to consider.'* There he faltered.

Within those few minutes he had taken on board his diagnosis, his prognosis and had begun thinking in practical terms. I realised then that I was out of my depth and that my training had not prepared me to know what to do. After he died I rather dutifully took some books out of the library on communication with the dying, but as a house officer I did not have time to read them. It was only later, interviewing patients with cancer for research, that my thoughts turned back to the clear sightedness of this man. He showed me that some patients can face more than we can as doctors and see the truth before us. They can also feel sympathy for us as we struggle behind.

My generation received minimal training in breaking bad news despite its obvious key role within clinical practice. This training now starts much earlier and has improved a great deal, but we need to remember that it demands a lot of young people in their early 20's who are still developing their 'emotional intelligence'.

The privilege of medical practice

My second major theme is the privilege of medical practice in all its triumph and failure. It is often possible to help others simply by listening carefully and many of my teachers demonstrated great empathy in front of us, but some didn't and I wouldn't say this was institutionalised. There is always the risk of 'getting onto your white horse' and becoming very busy and important and sometimes immune, as it were, to suffering. The next tale shows what can happen when people feel their own perspective is ignored.

Tale 3: A nanny's stamina [3]

When I started as a senior house officer on the unit she was practically mute: the effort of speaking was immense, she could give none of the usual conversational cues and it was difficult to maintain such a one-sided encounter for long. She sat on the ward throughout the day, eschewing the group activities, her face conveying silent despair. *'I just can't do anything,'* she would manage. Later, she recalled how she had felt the predicament of others trying to draw her out, but when I asked what she felt her attendants should do in that situation, she replied, *'You can't, there's nothing anyone can do. When someone's like that you just have to leave them.'* None the less, I had gone every day to see her, asking her how she was and taking blood to check the levels of her various antidepressants.

She disliked taking the tablets and we kept increasing them. She acquiesced to this with that self-contained sense of having to suffer fools gladly that only the Scots can truly master. Of course, she was right and later we tipped her into mania, embarrassing her greatly at the things she then said. To begin with, as the drugs slowly took effect, she began to fret about her hair, which by then needed washing and the time she needed to get ready in the morning. But then, majestic in intricate cardigans, she took up her knitting and as she emerged so did part of her story, or that part of an era when she had been in control.

The notes gave the long history of her manic depressive illness and described her as an 'ex-nanny'. Feeling at the time I was having more than my fair share of nanny troubles, I was interested in her as a relic from a time when nannies seemed to me to have been real nannies. This encouraged her. She spoke of coming down from Scotland to the south coast of England with her employers to look after their four children. She described the large house, trimmed hedges, her uniform and the mother who dressed elegantly to receive and visit friends for lunch. She recounted her day off each week, the long hours and the evenings spent starching and pressing the children's clothes. Of course, she had an under-nanny to help her with this, but, she intimated, young girls these days didn't know their luck.

From my experience I tended to agree, but this domestic scene was later shattered. One day in this household she had been unwell with a fever heralding pneumonia. The mother, pregnant with her fifth child, had visited the nursery and the children had reported that Nanny was unwell. *'No she isn't. She's just pretending,'* the mother had replied.

Nanny had bit her lip, finished her day's work and later confronted the mother with the news that she was leaving. *'You should not have talked to me like that in front of the children,'* she said.

The children had cried all that night and in the morning the mother was contrite. She had not really meant it. *'How am I to cope with this next baby?'* she wailed.

'You should have thought of that in the first place,' came Nanny's retort. Off she sailed without references to land another job in no time.

Back on the ward she smiled a sad resigned smile. The stamina that kept her through the ups and downs of her current illness was part of the same strength of character that earlier meant she had not been able to know her place.

I think we have got to this stage in the English NHS where, for various reasons, people are less willing to bite their lip and many clinicians are feeling surprised, let down and under siege.

Increasing complexity of healthcare

My third theme is the increasing complexity of healthcare and the many efforts to sort out many obvious problems with care. We now have many new structures and initiatives for patient- or person-centred care, as well as for evidence-based medicine and patient safety. The focus on patient- or person-centred care has not always been central or precise, but I worry that the stock response to a sense of crisis within healthcare may be to propose another re-organisation, structure, new administrative processes and more supporting data collection. These activities are not

going to help make clinicians better able to manage more complex medical situations or to meet higher expectations. And, sadly, they tend to generate more paperwork for busy people. The amount of paper in medical records, for example, has increased and the fact that this may now be stored in electronic records does not mean that it gets inputted on its own. This final tale is an early reflection on the experience of evaluating possible improvements in care.

Tale 4: A sense of *déjà-vu* [4]

The room was homely, nestled in the basement and traversed by pipes encased in silver foil. With a sense of the inevitable I settled down. The clerks, now ignoring me, continued their cheery boasts of difficult finds and commiserations on last minute telephone requests. Record systems are not difficult to master - colour-codes, consecutive numbers, paired or in reverse, always some quirk - but the real problem is those booked out eons ago which force a trail around distant departments. At least this time mine were waiting and marked for my attention. I was interested to see what I could glean about a recent waiting list initiative for suspected colorectal cancer, but I wondered, dispiritedly, why the mechanics of audit remained the same despite all the investment and talk.

Out of clinical practice for several years, however, I was soon fascinated by an array of tummy troubles and developing again that sense of competence in retrieving deeply buried histology results and GP referral letters. But the records now seemed swollen. Care plans, charts, protocols, explanations, detailed summaries, forms relinquishing hospital responsibility, all stuffed into those never-to-be-filed pockets of history. However, as my archaeology continued, these gave way to the slimmer volumes of older patients rarely in hospital. Letters of three sentences described the positive features of diagnosis and management. What a joy to audit these. Their tissue-thin slips and uneven type-written ink conjuring up an old NHS of no-nonsense doctors and grateful patients.

And then in 1957 I found it - from a senior registrar to a young woman, previously attending the gynaecology clinic:

‘Dear Mrs X,

I find that your name is still on the waiting list and that you have not yet been admitted to hospital for your operation. Would you please indicate on the attached form whether a) you still have the same trouble b) still wish to be admitted to hospital, or c) have received treatment elsewhere, by striking out the words which do not apply in your case.

1. My symptoms continue/have disappeared.
2. I still wish/do not wish to be admitted to hospital.
3. I have/have not received treatment elsewhere.

Please return the stamped addressed envelope provided.’

Mrs X had replied in a small, careful hand, that she was well and did not need an operation, thank you.

An early example of patient-centred decision-making or the discovery of a 40-year cycle in waiting list initiatives?

Conclusions

My final reflections are that although patient- or person-centred healthcare is gaining ground, the key elements to it are time with one person who can take that time to understand, build trust and ensure that what they say is going to happen to the patient actually does happen. Clinicians of all kinds need time to learn how to practise it and to teach it and the system needs to support them while they learn this and when they fail which inevitably they will at times. It feels to me, however, as if clinicians are actually being managed into being mini-managers or administrators who need to get through a great many other different tasks and see more patients as well. We simply do not know yet whether these new structures or financial incentives actually lead to better person-centred care. So my conclusion is that I am now forced back to research and the need for evidence about what exactly are the right cultures, organisations and structures that support the people doing the job of person-centred care. I want to know much more about how initiatives succeed or fail and how much work they create to justify themselves and how much clinician or patient time they take away from the real business of care.

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